State of Washington
837 Professional and Institutional
Encounter Data
Companion Guide

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Disclaimer

This companion guide contains data clarifications derived from specific business rules that apply exclusively to Washington State Medicaid processing for Washington State HCA. The guide also includes useful information about sending and receiving data to and from the Washington State ProviderOne system.

Revision History

Documented revisions are maintained in this document through the use of the Revision History Table shown below. All revisions made to this companion guide after the creation date are noted along with the date, page affected, and reason for the change.

Revision Level	Date	Page	Description	Change Summary
WAMMIS-CG837ENC-5010-01-02	12/27/10		Initial Document	
WAMMIS-CG837ENC-5010-01-03	02/02/2012		Version Number updated as a result of changes listed below	
Professional Encounter Functional Group Header – GS02	02/02/2012		Correction	Changed element description to read, "Please use the 9-digit alphanumeric submitter ID assigned during the enrollment process. This should be the same as Loop 1000A Data Element NM109 e.g. 1234567AA
Professional Encounter Loop 1000A Submitter Name	02/02/2012		Correction	NM109 – Removed "followed by spaces" from instructions
Professional Encounter Loop 2010AA Billing Provider Name	02/02/2012		Correction	NM102 – Changed description to read, "Please use the appropriate code" NM103 – Changed description to read, "Enter the Organization Name or the Last Name of the provider who billed the MCO or RSN"
Professional Encounter Loop 2010BA Subscriber City/State/Zip Code	02/02/2012		Correction	Removed identified use of element N404 – Country Code
Professional Encounter Loop 2010BB Billing Provider Secondary Identification	02/02/2012		Correction	Corrected Loop reference for elements REF01 and REF02 to read 2010BB. Previously elements were referenced to Loop 2010 AA
Professional Encounter Loop 2410 – Drug Information -LIN Segments -CTP Segments	02/02/2012		Addition	Added situation reference to use of Loop 2410 Drug Information when required for Managed Care Encounter submission

Institutional Encounter Functional Group Header – GS02	02/02/2012		Correction	Changed element description to read, "Please use the 9-digit alphanumeric submitter ID assigned during the enrollment process. This should be the same as Loop 1000A Data Element NM109 e.g. 1234567AA
Institutional Encounter Functional Group Header – GS02	02/02/2012		Correction	Changed element description to read, "Please use the 9-digit alphanumeric submitter ID assigned during the enrollment process. This should be the same as Loop 1000A Data Element NM109 e.g. 1234567AA
Institutional Encounter Loop 1000A Submitter Name	02/02/2012		Correction	NM109 – Removed "followed by spaces" from instructions
Institutional Encounter Loop 2010AA Billing Provider Name	02/02/2012		Correction	NM103 – Changed description to read, "Enter the Organization Name or the Last Name of the provider who billed the MCO or RSN"
Institutional Encounter Loop 2010BB	02/02/2012		Correction	Payer Name Title incorrectly reference Loop 2010BC. Technical Specifications have been updated to correctly reference 2010BB
Institutional Encounter Loop 2410 – Drug Information -LIN Segments -CTP Segments	02/02/2012		Addition	Added situation reference to use of Loop 2410 Drug Information when required for Managed Care Encounter submission
WAMMIS-CG837ENC-5010-01-04	02/27/2012		Version number updated due to the inclusion of full Companion Guide Boilerplate information	
WAMMIS-CG837ENC-5010-01-05	06/2013		Update per ASC X12 recommendations	
WAMMIS-CG837ENC-5010-01-06	06/01/2017		Updated to reflect additional HCP requirements for encounter submissions	Updated to reflect use of Loop 2400, data elements HCP11 and HCP12 for 837 Professional Encounters

				Updated to reflect use of Loop 2300 and 2400, data elements HCP11 and HCP12 for 837 Institutional Encounters
WAMMIS-CG837ENC-5010-01-07	11/07/2018		Addition	Updated to add Agency Number Site ID
WAMMIS-CG837ENC-5010-01-07	11/07/2018		Addition	Updated to add requirement for Evidence-Based Practice (EBP) codes
WAMMIS-CG837ENC-5010-01-07	11/07/2018		Updates	Updated references for Regional Support Network (RSN) to Behavioral Health Organization (BHO)
WAMMIS-CG837ENC-5010-01-07	3/13/2019		Updates	Changed reference from "Agency Number Site ID" to "Site-Specific, Department of Health Licensure Number
WAMMIS-CG837ENC-5010-01-07	3/13/2019		Addition	Updated to reflect use of Loop 2300 for Prior Authorization
WAMMIS-CG837ENC-5010-01-08	4/14/2020		Updates	Updated verbiage, screen prints and web links.
WAMMIS-CG837ENC-5010-01-09	5/27/2022		Addition	Addition of HCP 03 segments in Professional and Institutional at both Header and Line levels
WAMMIS-CG837ENC-5010-01-10	09/01/2022		Update	Update instructions in the comments sections for 2000B SBR03 and 2010BA NM109
WAMMIS-CG837ENC-5010-01-11	06/26/2023		Addition	Addition of requirements for Electronic Visit Verification (EVV) data for Home Health services.
WAMMIS-CG837ENC-5010-01-12	10/17/2023		Addition	Addition of Rendering Provider to 837I to meet Electronic Visit Verification (EVV) data for Home Health services requirements.
WAMMIS-CG837ENC-5010-01-13	2/24/2025		Update	Update Logos and formatting

Contents

1 Introduction

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) includes requirements that national standards be established for electronic health care transactions, and national identifiers for providers, health plans, and employers. This requires Washington State Health Care Authority (HCA) to adopt standards to support the electronic exchange of administrative and financial health care transactions between covered entities (health care providers, health plans, and healthcare clearinghouses).

The intent of these standards is to improve the efficiency and effectiveness of the nation's health care system by encouraging widespread use of electronic data interchange standards in health care. The intent of the law is that all electronic transactions for which standards are specified must be conducted according to the standards. These standards were developed by processes that included significant public and private sector input.

Encounters are not HIPAA named transactions and the 837I and 837P Implementation Guides were used as a foundation to construct the standardized HCA encounter reporting process.

1.1 Document Purpose

Companion Guides are used to clarify the exchange of information on HIPAA transactions between the HCA ProviderOne system and its trading partners. HCA defines trading partners as covered entities that either submit or retrieve HIPAA batch transactions to and from ProviderOne.

> This Companion Guide is intended for trading partner use in conjunction with the ASC X12N Implementation Guides listed below. The ASC X12 TR3s that detail the full requirements for all HIPAA mandated transactions are available at http://store.x12.org/store/

The Standard Implementation Guides for Claim Transaction is:
- ☐ Healthcare Claim/(Encounters): Professional (837) 005010X222
- ☐ Healthcare Claim/(Encounters): Institutional (837) 005010X223

HCA has also incorporated all of the approved 837 Professional and 837 Institutional Addenda listed below.
- ☐ Healthcare Claim/(Encounters): Professional (837) 005010X222A1
- ☐ Healthcare Claim/(Encounters): Institutional (837) 005010X223A1
- ☐ Healthcare Claim/(Encounters): Institutional (837) 005010X223A2

1.1.1 Intended Users

Companion Guides are to be used by members/technical staff of trading partners who are responsible for electronic transaction/file exchanges.

1.1.2 Relationship to HIPAA Implementation Guides

Companion Guides are intended to supplement the HIPAA Implementation Guides for each of the HIPAA transactions. Rules for format, content, and field values can be found in the Implementation Guides. This Companion Guide describes the technical interface environment with HCA, including connectivity requirements and protocols, and electronic interchange procedures. This guide also provides specific information on data elements and the values required for transactions sent to or received from HCA.

Companion Guides are intended to supplement rather than replace the standard Implementation Guide for each transaction set. The information in these documents is not intended to:

- Modify the definition, data condition, or use of any data element or segment in the standard Implementation Guides.

- Add any additional data elements or segments to the defined data set.

- Utilize any code or data values that are not valid in the standard Implementation Guides.

- Change the meaning or intent of any implementation specifications in the standard Implementation Guides.

1.2 Transmission Schedule

N/A

2 Technical Infrastructure and Procedures

2.1 Technical Environment

2.1.1 Communication Requirements

This section will describe how trading partners can send 837 Encounters Transactions to HCA using 2 methods:

- Secure File Transfer Protocol (SFTP)
- ProviderOne Web Portal

2.1.2 Testing Process

Completion of the testing process must occur prior to submitting electronic transactions in production to ProviderOne. Testing is conducted to ensure the following levels of HIPAA compliance:

1. Level 1 – Syntactical integrity: Testing of the EDI file for valid segments, segment order, element attributes, testing for numeric values in numeric data elements, validation of X12 or NCPDP syntax, and compliance with X12 and NCPDP rules.

2. Level 2 – Syntactical requirements: Testing for HIPAA Implementation Guide-specific syntax requirements, such as limits on repeat counts, used and not used qualifiers, codes, elements and segments. It will also include testing for HIPAA required or intra-segment situational data elements, testing for non-medical code sets as laid out in the Implementation Guide, and values and codes noted in the Implementation Guide via an X12 code list or table.

Additional testing may be required in the future to verify any changes made to the ProviderOne system. Changes to the ANSI formats may also require additional testing. Assistance is available throughout the testing process.

Trading Partner Testing Procedures

1. ProviderOne companion guides and trading partner enrollment package are available for download via the web at: HIPAA Electronic Data Interchange (EDI) | Washington State Health Care Authority

2. The Trading Partner completes the Trading Partner Agreement and submits the signed agreement to HCA.

Submit to: HCA HIPAA EDI Department

626 8th Avenue SE

PO Box 45564

Olympia, WA 98504-5564

For Questions call 1-800-562-3022 ext 16137

3. The trading partner is assigned a Submitter ID, Domain, Logon User ID and password.

4. The trading partner submits all HIPAA test files through the ProviderOne web portal or Secure File Transfer Protocol (SFTP).

   - Web Portal URL: https://www.waproviderone.org/edi
   - SFTP URL: sftp://ftp.waproviderone.org/

5. The trading partner downloads acknowledgements for the test file from the ProviderOne web portal or SFTP.

6. If ProviderOne system generates a positive TA1 and positive 999 acknowledgement, the file is successfully accepted. The trading partner is then approved to send X12N 837 Encounters files in production.

7. If the test file generates a negative TA1 or negative 999 acknowledgment, then the submission is unsuccessful and the file is rejected. The trading partner needs to resolve all the errors that are reported on the negative TA1 or negative 999 and resubmit the file for test. Trading partners will continue to test in the testing environment until they receive a positive TA1 and positive 999.

2.1.3 Who to contact for assistance

Email: HIPAA-Help@hca.wa.gov

   - All emails result in the assignment of a Ticket Number for problem tracking

- Information required for initial email:
   - Name
   - Phone Number
   - Email Address
   - 7 Digit domain/ProviderOne ID
   - Transaction you are inquiring about
   - File Name
   - Detailed description of concern
- Information required for follow up call(s):
   - Assigned Ticket Number

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2.2 Upload batches via Web Interface

Once logged into the ProviderOne Portal, select the Admin Tab and the following options will be presented to the user:

Scroll down to the HIPAA options on the right side to manage the HIPAA transactions.

In the HIPAA section, the user can Submit file and Retrieve Acknowledgement/Response as shown below:

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 In order to upload a file, the following steps are followed:

Click on the Upload button to upload a HIPAA file
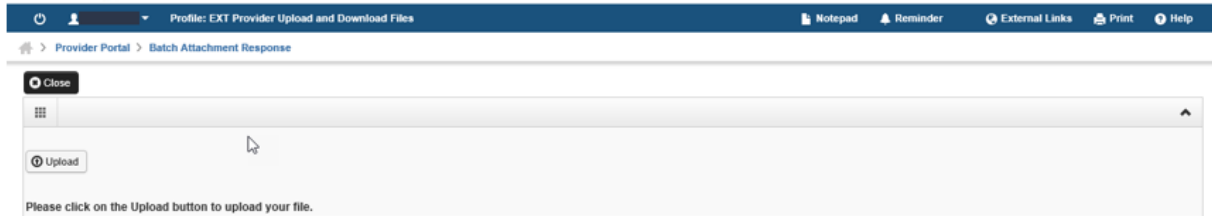
On file upload page click on the Browse button to attach HIPAA file from local file system. After selecting the file from the local file system, press OK to start the upload.
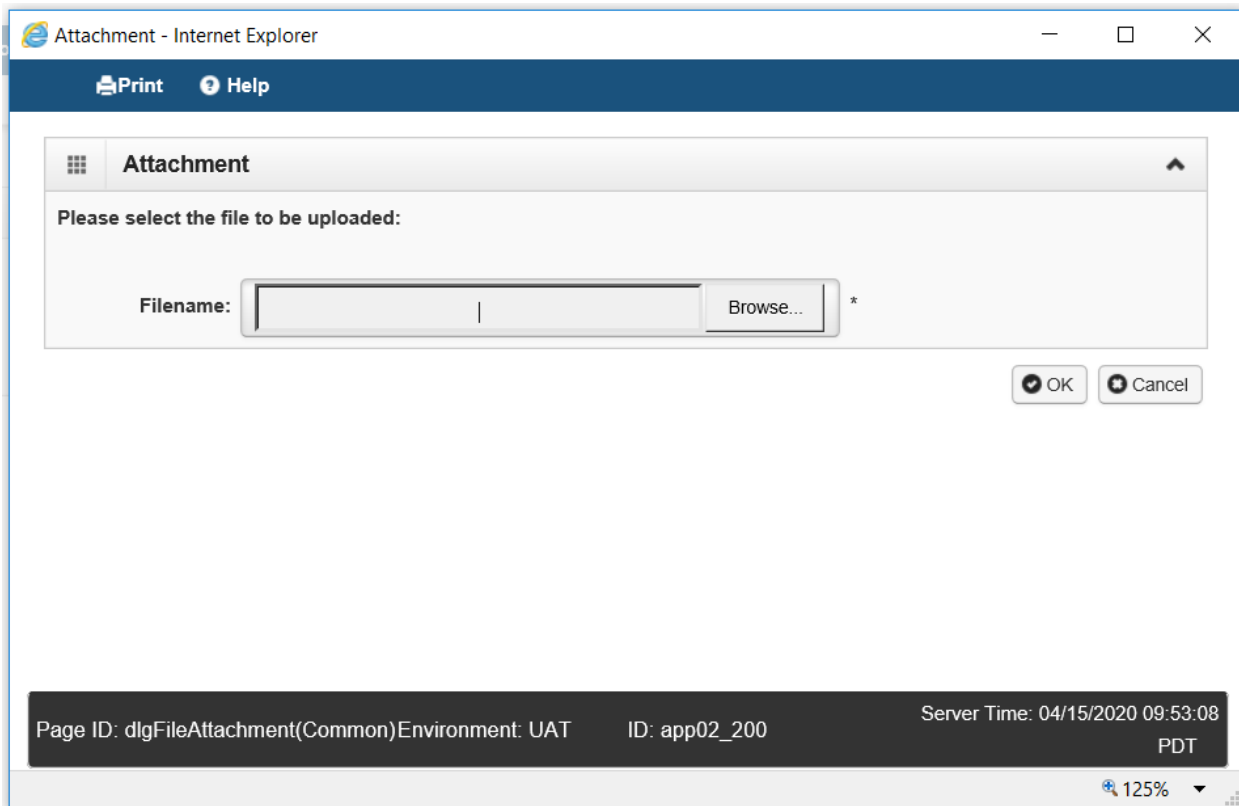
Once the file is uploaded to the ProviderOne system success/failure message is displayed on the screen along with transmission details.

Select Retrieve Acknowledgement/Response option from the HIPAA screen to retrieve Acknowledgements/Responses (TA1, 999, 271, 277, 820, 834, 835, or 277U) as shown below:

2.3 Set-up, Directory, and File Naming Convention

2.3.1 SFTP Set-up

Trading partners can contact HIPAA-help@hca.wa.gov for information on establishing connections through the FTP server. Upon completion of set-up, they will receive additional instructions on FTP usage.

2.3.2 SFTP Directory Naming Convention

There would be two categories of folders under Trading Partner's SFPT folders:

1. **TEST – Trading Partners should submit and receive their test files under this root folder**

2. **PROD – Trading Partners should submit and receive their production files under this root folder**

3. **README – This folder will include messages regarding password update requirements, outage information and general SFTP messages.**

Following folder will be available under TEST/PROD folder within SFTP root of the Trading Partner:

'HIPAA_Inbound' - This folder should be used to drop the Inbound files that need to be submitted to HCA

'HIPAA_Ack' - Trading partner should look for acknowledgements to the files submitted in this folder. TA1, 999 and custom error report will be available for all the files submitted by the Trading Partner

'HIPAA_Outbound' – X12 outbound transactions generated by HCA will be available in this folder

'HIPAA_Error' – Any inbound file that is not HIPAA compliant or is not recognized by ProviderOne will be moved to this folder

'HIPAA Working' – There is no functional use for this folder at this time

Folder structure will appear as:

```
□ 📁 PROD
     📁 HIPAA_Ack
     📁 HIPAA_Error
     📁 HIPAA_Inbound
     📁 HIPAA_Outbound
     📁 HIPAA_Working
□ 📁 Test
     📁 HIPAA_Ack
     📁 HIPAA_Error
     📁 HIPAA_Inbound
     📁 HIPAA_Outbound
     📁 HIPAA_Working
```
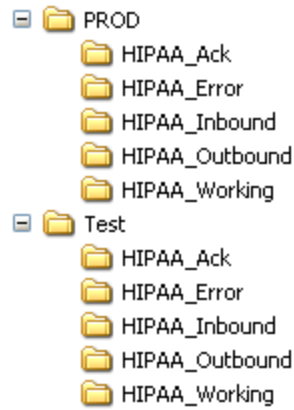
2.3.3 File Naming Convention

The HIPAA Subsystem Package is responsible for assisting ProviderOne activities related to Electronic Transfer and processing of Health Care and Health Encounter Data, with a few exceptions or limitations.

HIPAA files are named:

For Inbound transactions:

HIPAA.<TPId>.<datetimestamp>.<originalfilename>.<dat>

Example of file name: HIPAA.101721500.122620072100_P_1.dat

▪ <TPId> is the Trading Partner Id

▪ <datetimestamp> is the Date timestamp

▪ <originalfilename> is the original file name which is submitted by the trading partner.

▪ All HIPAA submitted files MUST BE **.dat** files or they will not be processed

2.4 Transaction Standards

2.4.1 General Information

HIPAA standards are specified in the Implementation Guide for each mandated transaction and modified by authorized Addenda. Encounter Transactions utilize both the 837P and 837I Implementation Guides. Currently, the 837P has one Addendum and the 837I transaction has two Addenda. These Addenda have been adopted as final and are incorporated into HCA requirements.

An overview of requirements specific to the transaction can be found in the 837P and 837I Implementation Guides. Implementation Guides contain information related to:

- Format and content of interchanges and functional groups

- Format and content of the header, detailer and trailer segments specific to the transaction

- Code sets and values authorized for use in the transaction

- Allowed exceptions to specific transaction requirements

Transmission sizes are limited based on two factors:

- Number of Segments/Records allowed by HIPAA Standards

- HCA file size limitations

HIPAA standards limits the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments.

HCA limits a file size to 50 MB while uploading HIPAA files through the ProviderOne web portal and 100 MB through FTP.

2.4.2 Data Format

Delimiters

The ProviderOne will use the following delimiters on outbound transactions:

- Data element separator, Asterisk, (*)

- Sub-element Separator, Colon, (:)

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- Segment Terminator, Tilde, (~)

- Repetition Separator, Caret, (^)

2.4.3 Data Interchange Conventions

When accepting 837 Encounters transactions from trading partners, HCA follows HIPAA standards. These standards involve Interchange (ISA/IEA) and Functional Group (GS/GE) Segments or "outer envelopes". All 837 Encounters Transactions should follow the HIPAA guideline. Please refer to the 837 Implementation Guide for ISA/IEA envelop, GS/GE functional group and ST/SE transaction specifications.

The ISA/IEA Interchange Envelope, unlike most ASC X12 data structures has fixed field length. The entire data length of the data element should be considered and padded with spaces if the data element length is less than the field length.

2.4.4 Acknowledgement Procedures

Once the file is submitted by the trading partner and is successfully received by the ProviderOne system, a response in the form of TA1 and 999 acknowledgment transactions will be placed in appropriate folder (on the SFTP server) of the trading partner. The ProviderOne system generates positive TA1 and positive 999 acknowledgements, if the submitted HIPAA file meets HIPAA standards related to syntax and data integrity. For files that do not meet the HIPAA standards, a negative TA1 and/or negative 999 are generated and sent to the trading partner.

2.4.5 Rejected Transmissions and Transactions

837 Encounters will be rejected if the file does not meet HIPAA standards for syntax, data integrity and structure (Strategic National Implementation Process (SNIP) type 1 and 2).

3 Transaction Specifications

837 Professional Encounters

Page	Loop	Segment	Data Element	Element Name	Comments
Interchange Control Header (ISA)					
App.C	Envelope	ISA	01	Authorization Information Qualifier	Please use '00'.
App.C	Envelope	ISA	03	Security Information Qualifier	Please use '00'.
App.C	Envelope	ISA	05	Interchange ID Qualifier	Please use 'ZZ'.
App.C	Envelope	ISA	06	Interchange Sender ID	Please use the nine-digit alphanumeric submitter ID assigned during the enrollment process, followed by spaces (e.g. 1234567AA).
App.C	Envelope	ISA	07	Interchange ID Qualifier	Please use 'ZZ'.
App.C	Envelope	ISA	08	Interchanger Receiver ID	Please enter '77045' followed by spaces.
App.C	Envelope	ISA	11	Repetition Separator	Please use '^'.
App.C	Envelope	ISA	16	Component Element Separator	Please use ':'.
Functional Group Header (GS)					
App.C	Envelope	GS	02	Application Sender Code	Please use the nine-digit alphanumeric submitter ID assigned during the enrollment process. This should be the same as Loop 1000A, Data Element NM109 (e.g. 1234567AA).
App.C	Envelope	GS	03	Applications Receivers Code	Please use '77045'.
Beginning Hierarchical Transaction (BHT)					

71	Header	BHT	02	Transaction Set Purpose Code	Please use '00'.
72	Header	BHT	06	Claim or Encounter Indicator	Please use 'RP' for encounter.
Submitter Name (Loop 1000A)					
75	1000A	NM1	09	Submitter ID	Please use the nine-digit alphanumeric submitter ID assigned during the enrollment process (e.g. 1234567AA). This should be the same as ISA06 and GS02.
Receiver Name (1000B)					
80	1000B	NM1	03	Receiver Name	Please enter 'WA State HCA'.
80	1000B	NM1	09	Receiver Primary Identifier	Please use '77045'.
Billing Provider Specialty Information (2000A)					
83	2000A	PRV			NOTE: For medical and behavioral health encounters this must always be the taxonomy for the provider who billed the MCO.
Billing Provider Name (2010AA)					
88	2010AA	NM1			NOTE: For medical and behavioral health encounters this must always be the provider who billed the MCO.
Subscriber Information (Loop 2000B)					
117	2000B	SBR	03	Reference Identification	SBR03 is not used for medical or behavioral health (BH) encounters submitted by MCOs. For encounters submitted by ASOs, the ASO unique consumer ID *MUST* be entered (even if already entered in NM109).
118	2000B	SBR	09	Claim Filing Indicator Code.	Please enter 'MC'.
Subscriber Name (Loop 2010BA)					

123	2010BA	NM1	09	Identification Code	For medical and behavioral health (BH) encounters submitted by MCOs for Medicaid clients, please enter the ProviderOne Client ID. This ID is 11 digits in length and is alphanumeric in the following format: nine numeric digits followed by 'WA'. Example: 123456789WA For encounters submitted by ASOs, one of the following **MUST** be entered: 1) The ProviderOne Client ID; or 2) The ASO unique consumer ID (i.e., this is the same information reported in Loop 2000B SBR03.)
Subscriber Address (Loop 2010BA)					
124	2010BA	N3			NOTE: For homeless clients please enter 'unknown' in N301.
Subscriber City/State/ZIP Code (Loop 2010BA)					
125	2010BA	N4			NOTE: For homeless clients please enter the city, state and zip code for the service provider.
Subscriber Demographic Information (Loop 2010BA)					
127	2010BA	DMG			NOTE: HCA requires the DMG segment to be submitted as the patient is always the subscriber.
Payer Name (Loop 2010BB)					
133	2010BB	NM1	03	Payer Name – Name last/Organization Name	Please enter 'WA State HCA'.
133	2010BB	NM1	09	Payer ID	Please use '77045'.
Billing Provider Secondary Identification (Loop 2010BB)					
140	2010BB	REF			Note: This segment is used to identify the MCO and ASO ProviderOne ID.

140	2010BB	REF	01	Billing Provider Secondary ID Qualifier	Please use 'G2' to identify the ProviderOne ID.
141	2010BB	REF	02	Billing Provider Secondary ID	Please enter nine-digit alphanumeric ProviderOne ID.
Claim Information (Loop 2300)					
Date – Admission (Loop 2300)					
176	2300	DTP			NOTE: Used only for medical and BH encounters submitted by MCOs when appropriate. Not used for ASO submitted encounters.
Date – Discharge (Loop 2300)					
177	2300	DTP			NOTE: Used only for medical and BH encounters submitted by MCOs when appropriate. Not used for ASO submitted encounters.
Prior Authorization (Loop 2300)					
		REF	01	Reference Identification Qualifier	Please enter 'G1'.
		REF	02	Reference Identification	Please enter the nine-digit Evidence-Based Practice (EBP) code.
Payer Claim Control Number (Loop 2300)					
196	2300	REF	02	Reference Identification	Please enter the 18 digit Transaction Control Number (TCN) of claim when CLM05-3 indicates the claim is a replacement or void.
Medical Record Number (Loop 2300)					
204	2300	REF			Used only for ASO submitted encounters when appropriate. Not used for medical or BH encounters submitted by MCOs.
Claim Pricing/Repricing Information (Loop 2300)					

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253	2300	HCP			NOTE: Used only for medical and BH encounters submitted by MCOs when appropriate. Not used for ASO submitted encounters.
253	2300	HCP	01	Pricing/Repricing Methodology	Please enter based on how the MCO reimbursed the claim: '00' = Claim denied by MCO; or '02' = MCO paid a non-capitated amount; or '07' = MCO paid based on a capitation arrangement.
253	2300	HCP	02	Monetary Amount – Total Claim Paid Amount	MCOs to report the 'Amount Paid' (amount that MCO paid) to the Billing/Pay-to provider or $0.00 if MCO denied the claim.
253	2300	HCP	03	Monetary Amount	MCO Allowed Amount (Usual and Customary)
Referring Provider Name (Loop 2310A)					
258	2310A	NM1			NOTE: Used only for medical and BH encounters submitted by MCOs when appropriate. Not used for ASO submitted encounters.
Referring Provider Secondary Identification (Loop 2310A)					
260	2310A	REF			NOTE: Used only for medical and BH encounters submitted by MCOs when appropriate. Not used for ASO submitted encounters.
Rendering Provider Name (Loop 2310B)					
263	2310B	NM1			NOTE: Used only for medical and BH encounters submitted by MCOs. Not used for encounters submitted by ASOs as professional encounters are not reported below the CMHA level.
Service Facility Location Secondary Identification (Loop 2310C)					

275	2310C	REF	01	Reference Identification Qualifier	Please enter 'G2'.
276	2310C	REF	02	Reference Identification	Please enter the site-specific, Department of Health (DOH) License Number. Provide just the certification number and do not include preceding characters (i.e., ~~BHA.FS.~~60872639). DO NOT use the DSHS-DBHR Legacy License Number.
Other Subscriber Information (Loop 2320)					
298	2320	SBR	09	Claim Filing Indicator Code	Please use 'MB' when submitting Medicare Crossover Claims; otherwise use 'MC'.
Line Note (Loop 2400)					
465	2400	NTE	01	Note Reference Code	MCO – use appropriate code. ASO – use 'ADD'.
465	2400	NTE	02	Line Note Text	MCO – use as needed per the IG. ASO – refer to BHDS data dictionary.
Line Pricing/Re-pricing Information (Loop 2400)					
413	2400	HCP			NOTE: Used only for medical and BH encounters submitted by MCOs when appropriate. Not used for ASO submitted encounters.
413	2400	HCP	01	Pricing/Re-pricing Methodology	Please enter based on how the MCO reimbursed the claim: '00' = Claim denied by MCO; or '02' = MCO paid a non-capitated amount; or '07' = MCO paid based on a capitation arrangement.
413	2400	HCP	02	Monetary Amount – Total Claim Paid Amount	MCOs to report the 'Amount Paid' (amount that MCO paid) to the Billing/Pay-to provider or $0.00 if MCO denied the claim.

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413	2400	HCP	03	Monetary Amount	MCO Allowed Amount (Usual and Customary)
420	2400	HCP	11	Unit or Basis For Measurement Code	MCOs to use appropriate unit qualifier per IG.
420	2400	HCP	12	Quantity	MCOs to report number of paid units.
Rendering Provider Name (Loop 2420A)					
431	2420A	NM1			NOTE: Not used for ASO submitted encounters as professional encounters are not reported below the CMHA level.
Service Facility Location Secondary Identification (Loop 2420C)					
447	2420C	REF	01	Reference Identification Qualifier	Please enter 'G2'.
448	2420C	REF	02	Reference Identification	Please enter the site-specific, Department of Health (DOH) License Number. Provide just the certification number and do not include preceding characters (i.e., BHA.FS.60872639). DO NOT use the DSHS-DBHR Legacy License Number.

837 Institutional Encounters

Page	Loop	Segment	Data Element	Element Name	Comments
INTERCHANGE CONTROL HEADER					
App.C.4	ENVELOPE	ISA	01	Authorization Information Qualifier	Please use '00'.
App.C.4	ENVELOPE	ISA	03	Security Information Qualifier	Please use '00'.

App.C.4	ENVELOPE	ISA	05	Interchange ID Qualifier	Please use 'ZZ'.
App.C.4	ENVELOPE	ISA	06	Interchange Sender ID	Please use the nine-digit alphanumeric submitter ID assigned during the enrollment process followed by spaces (e.g. 1234567AA).
App.C.5	ENVELOPE	ISA	07	Interchange ID Qualifier	Please use 'ZZ'.
App.C.5	ENVELOPE	ISA	08	Interchange Receiver ID	Please enter '77045' followed by spaces.
App.C.5	ENVELOPE	ISA	11	Repetition Separator	Please use '^'.
App.C.6	ENVELOPE	ISA	16	Component Element Separator	Please use ':'.
FUNCTIONAL GROUP HEADER					
App.C.7	ENVELOPE	GS	02	Application Sender's Code	Please use the nine-digit alphanumeric submitter ID assigned during the enrollment process. This should be the same as Loop 1000A, Data Element NM109 (e.g. 1234567AA).
App.C.7	ENVELOPE	GS	03	Application Receiver's Code	Please use '77045'.
Beginning of Hierarchical Transaction					
68	HEADER	BHT	02	Transaction Set Purpose Code	Please use '00' for Original.
69	HEADER	BHT	06	Transaction Type Code	Please use 'RP' for encounters.
Loop ID 1000A - Submitter Name					

72	1000A	NM1	09	Identification Code	Please use the nine-digit alphanumeric submitter ID assigned during the enrollment process (e.g. 1234567AA).
Loop ID 1000B - Receiver Name					
77	1000B	NM1	03	Name Last or Organization Name	Please use 'WA State HCA'.
77	1000B	NM1	09	Identification Code	Please use '77045'.
Billing Provider Specialty Information					
80	2000A	PRV			NOTE: For medical and BH encounters this must always be the taxonomy for the provider who billed the MCO.
Loop ID 2010AA - Billing Provider Name					
85	2010AA	NM1			NOTE: For medical and BH encounters this must always be the provider who billed the MCO.
Subscriber Information					
110	2000B	SBR	03	Group or Policy number	SBR03 is not used for medical or BH encounters submitted by MCOs. For encounters submitted by ASOs, the ASO unique consumer ID *MUST* be entered (even if already entered in 2010BA NM109).
110	2000B	SBR	09	Claim Filing Indicator Code	Please use 'MC'.
Loop ID 2010BA - Subscriber Name					

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114	2010BA	NM1	09	Identification code	For medical and BH encounters submitted by MCOs for Medicaid clients, please enter the ProviderOne Client ID. This ID is 11 digits in length and is alphanumeric in the following format: nine numeric digits followed by 'WA'. Example: 123456789WA For encounters submitted by ASOs, one of the following **MUST** be entered: 1) The ProviderOne Client ID; or 2) The ASO unique consumer ID (i.e., this is the same information reported in Loop 2000B SBR03.)
Subscriber Address					
115	2010BA	N3			NOTE: For homeless clients please enter 'unknown' in N301.
Subscriber City/State/Zip Code					
116	2010BA	N4			NOTE: For homeless clients please enter the city, state and zip code for the service provider.
Subscriber Demographic Information					

| 118 | 2010BA | DMG | | | NOTE: HCA requires the DMG segment to be submitted as the patient is always the subscriber. |

Loop ID 2010BB - Payer Name					
123	2010BB	NM1	03	Last Name or Organization Name	Please use 'WA State HCA'.
123	2010BB	NM1	09	Identification Code	Please use '77045'.

Billing Provider Secondary Identification					
129	2010BB	REF	01	Reference Identification Qualifier	Please use 'G2'.
130	2010BB	REF	02	Reference Identification	Please enter nine-digit, ProviderOne ID for the MCO or ASO here.

Loop ID 2300 - Claim Information					
145	2300	CLM	05-1	Facility Code Value	MCO - Please enter appropriate place of service code. ASO – Facility Code Value must be '11' .

Prior Authorization (Loop 2300)					
		REF	01	Reference Identification Qualifier	Please enter 'G1'.
		REF	02	Reference Identification	Please enter the nine-digit Evidence-Based Practice (EBP) code.

Loop ID 2300 - Payer Claim Control Number					
166	2300	REF	02	Reference Identification	Please enter the 18 digit Transaction Control Number (TCN) of claim when CLM05-3 indicates the claim is a replacement or void.

| Diagnosis Related Group (DRG) Information | | | | | |

218	2300	HI			NOTE: Not used on ASO submitted encounters.
Principle Procedure Information					
240	2300	HI			NOTE: Not used on ASO submitted encounters.
Other Procedure Information					
243	2300	HI			NOTE: Not used on ASO submitted encounters.
Other Procedure Information Value Information (Code)					
284	2300	HI			NOTE: Not used on ASO submitted encounters.
Claim Pricing/Repricing Information					
314	2300	HCP			NOTE: Not used on ASO submitted encounters.
314	2300	HCP	01	Pricing Methodology	Please enter based on how the MCO reimbursed the claim: '00' = Claim denied by MCO; or '02' = MCO paid a non-capitated amount; or '07' = MCO paid based on a capitation arrangement.
314	2300	HCP	02	Monetary Amount	MCOs to report the 'Amount Paid' (amount that MCO paid) to the Billing/Pay-to provider or $0.00 if MCO denied the claim.

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314	2300	HCP	03	Monetary Amount	MCO Allowed Amount (Usual and Customary)
316	2300	HCP	11	Unit or Basis For Measurement Code	MCOs to use appropriate unit qualifier per IG.
316	2300	HCP	12	Quantity	MCOs to report number of paid units.
Attending Provider Name					
319	2310A	NM1			NOTE: For ASO submitted institutional encounters the attending provider will always be the E&T Center, based on the decision not to report below the E&T Center level.
Loop ID 2310D - Rendering Provider Name					
336	2310D	NM1		Rendering Provider Name	Enter the provider rendering service and NPI for Electronic Visit Verification (EVV) on Home Health Services claims. *If different rendering provider for each service line, submit in 2420C for each service line.
Service Facility Location Secondary Identification (2310E)					
342	2310E	NM1			Enter Clients service location in the example format below, for Electronic Visit Verification (EVV) on Home Health

					Services encounter claims. Example: NM1∗77∗2∗Clients Location (Home or otherwise) NOTE: Submitting this segment triggers the requirement for N3 and N4 in the same loop.
347	2310E	REF	01	Reference Identification Qualifier	Please enter 'G2'.
348	2310E	REF	02	Reference Identification	Please enter the site-specific, Department of Health (DOH) License Number. Provide just the certification number and do not include preceding characters (i.e., BHA.FS.60872639). DO NOT use the DSHS-DBHR Legacy License Number.
Other Subscriber Information (Loop 2320)					
356	2320	SBR	09	Claim Filing Indicator Code	Use 'MA' when submitting Medicare; otherwise use 'MC'.
Institutional Service Line (Loop 2400)					
424	2400	SV2	01	Product/Service ID	MCO – Please enter the revenue code for inpatient encounters using NUBC as code source. ASO – Must always use revenue code '0124'.

425	2400	SV2	02	Service Line Procedure Code	MCO – Please refer to the IG. For outpatient encounters when HCPCS/CPT code exists at line level. ASO – Not used.
425	2400	SV2	SV202-1	Product/Service ID Qualifier	MCO – Required if outpatient encounter and HCPCS/CPT code exists at line level. ASO – Not used.
426	2400	SV2	SV202-2	Product/Service ID	MCO – Please enter the primary procedure code. This is required for outpatient encounters and must be submitted with HCPCS/CPT procedure code (not ICD9/ICD10 procedure code). ASO – Not used.
426	2400	SV2	SV202-3	Procedure Modifier	MCO – Please enter the procedure code modifier. This is required for outpatient encounters and if it clarifies the procedure. ASO – Not used.

427	2400	SV2	SV202-7	Time the service begins and ends.	Enter service begin and end times in HHMM-HHMM format for Electronic Visit Verification (EVV) on Home Health Services encounter claims.
Date - Service Date (Loop 2400)					
434	2400	DTP			NOTE: Not used for ASO submitted encounters.
Line Pricing/Re-pricing Information (Loop 2400)					
443	2400	HCP			NOTE: Used only for medical and BH encounters submitted by MCOs when appropriate. Not used for ASO submitted encounters.
443	2400	HCP	01	Pricing Methodology	Please enter based on how the MCO reimbursed the claim: '00' = Claim denied by MCO; or '02' = MCO paid a non-capitated amount; or '07' = MCO paid based on a capitation arrangement.
443	2400	HCP	02	Monetary Amount	MCOs to report the 'Amount Paid' (amount that MCO paid) to the Billing/Pay-to provider or $0.00 if MCO denied the claim.

443	2400	HCP	03	Monetary Amount	MCO Allowed Amount (Usual and Customary)
447	2400	HCP	11	Unit or Basis For Measurement Code	MCOs to use appropriate unit qualifier per IG.
447	2400	HCP	12	Quantity	MCOs to report number of paid units.
LIN – Drug Information (Loop 2410)					
450	2410	LIN			NOTE: Not used for ASO submitted encounters.
CTP – Drug Quantity					
452	2410	CTP			NOTE: Not used for ASO submitted encounters.
Loop ID 2420C - Rendering Provider Name					
336	2420C	NM1		Rendering Provider Name	Enter the provider rendering service and NPI for Electronic Visit Verification (EVV) on Home Health Services claims.